

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

6691

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF (RURAL)</b>		c. LENGTH OF STAY IN 1b <b>16 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF (RURAL)</b>	
		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH HAROLD BERRY</b>		4. DATE OF DEATH <b>JUNE 27 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 16 1943</b>
9. AGE (In years last birthday) <b>16 yrs.</b>		IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>THOMAS HAROLD BERRY</b>		14. MOTHER'S MAIDEN NAME <b>VIOLET E. DEMENT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Violet E BERRY</b>		Address <b>WALDORF MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>835X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Tractor falling on chest</b> (c) <b>Tractor falling on chest</b> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 min</b> <b>4 min</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Cultivating corn - tractor overturned.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6-27 1959</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>FARM</b>		20f. (City or town) (County) (State) <b>WALDORF, CHARLES, MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>V.B. DETTOR</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>V.B. DETTOR</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-30-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON DAT</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stonett Funeral Home WALDORF MD</b>		24a. REC'D BY REGISTRAR <b>JUN 30 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Robert L. Hume</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6692 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata (Rural)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Plata (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last George Kenneth Bowie		4. DATE OF DEATH Month Day Year June 23, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 17, 1935
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Milling-Lumber	11. BIRTHPLACE (State or foreign country) Charles Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Richard Bowie		14. MOTHER'S MAIDEN NAME Cora E. Alvey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes	17. INFORMANT Mary L. Bowie- Wife
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 910.3 Crush injuries of head and face DUE TO (b) and fracture of left femur and DUE TO (c) both humeri PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) none		INTERVAL BETWEEN ONSET AND DEATH 0	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 16' oak log rolled off of truck onto head of deceased.	
20c. TIME OF INJURY Month, Day, Year Hour 9:00 AM 6-23-59	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FACTORY	20f. (City or town) (County) (State) La Plata, Charles, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE V.B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) V. B. DETTOR		DATE SIGNED 6-24-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/25/1959	22c. NAME OF CEMETERY OR CREMATORY Dentsville - Methodist	22d. LOCATION (City, town, or county) (State) Dentsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. - La Plata, Md.		24a. REC'D BY REGISTRAR DATE JUN 29 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



6693

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Hughesville</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Hayden Bowling Sr.</u>				4. DATE OF DEATH Month Day Year <u>June 11, 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 1, 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postmaster</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James M. Bowling</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-07-273</u>		17. INFORMANT <u>Mrs. James H. Bowling, Hughesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIO-SCLEROSIS.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS.</u> <u>10 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY, 1948</u> , to <u>JUNE 11, 1959</u> , that I last saw the deceased alive on <u>JUNE 11, 1959</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>HUGHESVILLE, MD.</u> DATE SIGNED <u>6/13/59</u>							
ACTUAL SIGNATURE <u>John H. Griffin</u> M.D.				PHYSICIAN'S NAME (Type) <u>JOHN H. GRIFFIN</u> <u>Hughesville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-13-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



It should be noted that the subject of this report is a white male, aged 22, born 6-13-22, residing at 22 Waverly, Brighton, Mass.

On 6-13-22, 22 Waverly, Brighton, Mass.

Name		James M. Bowland	
Age		22	
Sex		Male	
Race		White	
Birth Date		June 11, 1899	
Birth Place		Hudsonville, Mich.	
Occupation		Postmaster	
Education		High School	
Marital Status		Single	
Previous Residence		Hudsonville, Mich.	
Reason for Leaving		To seek employment	
Date of Leaving		June 11, 1922	
Destination		Brighton, Mass.	
Remarks		Subject is a white male, aged 22, born 6-13-22, residing at 22 Waverly, Brighton, Mass.	

James M. Bowland  
Postmaster  
Hudsonville, Mich.  
June 11, 1922

Hudsonville, Mich.  
Charles  
June 11, 1922

CERTIFICATE OF DEATH

6694

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Waldorf</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Miami</u> 48X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1420 Brickell Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Marie</u> Last <u>Burke</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUL 15, 1879</u>	9. AGE (In years lost birthday) <u>79</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Egertors</u>				14. MOTHER'S MAIDEN NAME <u>Margaret UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Vincent Burke, Waldorf, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Cerebral - Prol D</u> DUE TO (c) <u>Regen Process</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 6</u> , 19 <u>58</u> , to <u>Aug 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Richard H Dobson</u> M.D. <u>Baltimore, Md</u> <u>6-28-59</u> PHYSICIAN'S NAME (Type) <u>Richard H Dobson</u> <u>Baltimore, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Darby, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The Faith Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased Anna Marie Kornek		2. Sex F	
3. Date of birth July 12, 1919		4. Place of birth Lansing, Michigan	
5. Usual residence Lansing, Michigan		6. Cause of death No	
7. Date of death July 12, 1968		8. Place of death Lansing, Michigan	
9. Signature of physician [Signature]		10. Signature of registrar [Signature]	
11. Name of funeral home [Name]		12. Name of cemetery [Name]	
13. Name of informant [Name]		14. Address of informant [Address]	
15. Telephone number [Number]		16. Other remarks [Remarks]	

1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 should be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	c. LENGTH OF STAY IN 1b 16 Hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Potomac Heights, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicans Memorial Hospital		d. STREET ADDRESS 146 Circle Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) DONALD First ALFRED Middle CONNER Last		4. DATE OF DEATH JUNE 13 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1951
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY at School	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard C. Conner	
14. MOTHER'S MAIDEN NAME Naomi E. Sherman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Richard C. Conner - Potomac Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Basal Skull Fracture DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 hr. 40 min. 16 hr. 40 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by truck while walking	
20c. TIME OF INJURY Month, Day, Year Hour 1:15 P.M. 6-12 1959	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Glymont, Charles, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE V.B. Detton		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) V. B. DETTOR, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-13-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/15/1959	22c. NAME OF CEMETERY OR CREMATORY Full Gosphel Cemetery	22d. LOCATION (City, town, or county) (State) Cederville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc.		ADDRESS Archart Funeral Home, Inc. - La Plata, Md.	
24a. REC'D BY REGISTRAR DATE JUN 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneel	

MEDICAL CERTIFICATION

066

08

2

M

I

NEW STATE  
HEALTH DEPT.

1

LABORATORY

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
FIRST MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6696 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15 Diffenbach</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
3. NAME OF DECEASED (Type or print) <u>Ellen</u> First <u>Mildred</u> Middle <u>Coombs</u> Last		f. DATE OF DEATH <u>June 18 1959</u> Month <u>June</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-25</u> 9. AGE (in years last birthday) <u>33</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Issue, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Alexander Hill</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Browner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Andrew Coombs, Indian Head, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>5 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank A. Susan</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank A. Susan M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/23/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Issue, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u> ADDRESS <u>La Plata, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 25 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haus</u>

DATE SIGNED  
6-18-59

1000

6697

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaPlata</u>				c. LENGTH OF STAY IN 1b <u>25-Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hospital, LaPlata Md.</u>				e. STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or print) <u>Catherine Claggett Dent</u>				4. DATE OF DEATH <u>6-25-59</u> Month <u>6</u> Day <u>25</u> Year <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W-US</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-82</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u>X</u> Min. <u>2</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Prince George County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas Claggett</u>				14. MOTHER'S MAIDEN NAME <u>Julia Hawkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Daughter-Mrs. Julia Hungerford</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Metastases Both Lungs, (Carcinoma Left Breast 2-Years</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma left Breast,</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3-Yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>5-31-59</u> , 19 <u>59</u> , to <u>6-25-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-25-59</u> , 19 <u>59</u> , and that death occurred at <u>12:55A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Indian Head Md</u> DATE SIGNED <u>6-25-59</u>							
ACTUAL SIGNATURE <u>James E. Andrews MD</u>		PHYSICIAN'S NAME (Type) <u>James E. Andrews MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/29/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u> ADDRESS <u>La Plata, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>JUL 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. After it is filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Chalres</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Bryantown</b> <b>Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicans Memorial H</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b> <b>RUTH</b> <b>FARMER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 24, 1959</b>
9. AGE (In years last birthday) <b>30</b>		10. IF UNDER 1 YEAR Months <b>30</b> Days <b>30</b> Hours <b>30</b> Min. <b>30</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Child</b>	
11. BIRTHPLACE (State or foreign country) <b>Meuport Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Swann</b>		14. MOTHER'S MAIDEN NAME <b>Mary M Farmer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Joseph H Bowman</b>		Address <b>Bryantown Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fluid and Electrolyte Imbalance</b> <b>772.0</b> DUE TO (b) <b>Vomiting</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wh.</b> <b>1 wh.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no injury</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>no injury</b> a. m. <b>no injury</b> p. m. <b>no injury</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>no injury</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>no injury</b>		20f. (City or town) (County) (State) <b>Bryantown, Charles, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>V. B. DETTOR</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>V. B. DETTOR</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-23-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried June 23-59 St Marys</b>		22b. DATE THEREOF <b>June 23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Bryantown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Prohart Funeral Home Inc</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 29 '59</b>	
ADDRESS <b>Prohart Funeral Home Inc</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6699 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Benedict</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Poloma/River Patuxent River</b>		d. STREET ADDRESS <b>1651 Lamont Street N. W.</b>	
3. NAME OF DECEASED (Type or print) <b>Regino M. Garcia</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 8, 1934</b>
9. AGE (In years last birthday) <b>24</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bussboy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
11. BIRTHPLACE (State or foreign country) <b>Havana, Cuba</b>		12. CITIZEN OF WHAT COUNTRY? <b>Cuban Republic</b>	
13. FATHER'S NAME <b>Miguel Garcia</b>		14. MOTHER'S MAIDEN NAME <b>Victoria Montalvo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miguel Garcia</b>		Address <b>1651 Lamont St. N. W., D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Accidental Drowning</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 min.</b> <b>2 min.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none known</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While swimming - possibly abdominal cramps</b>	
20c. TIME OF INJURY Month, Day, Year <b>Ca. 3:50 PM 6-23-59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>	20f. (City or town) (County) (State) <b>Benedict, Charles, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>V.B. DETTOR</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>V.B. DETTOR</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE WHEREOF <b>6-27-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Calon Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>TAMPA, FLORIDA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Archart &amp; Home</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6700 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06691

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Point</b>		c. LENGTH OF STAY IN 1b <b>X</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tompkinsville</b>		d. STREET ADDRESS <b>/</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANCIS</b> Middle <b>ROGER</b> Last <b>GOLDSMITH</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1935 July 21, 1935</b>
9. AGE (In years last birthday) <b>23</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Hand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>on Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George A. Goldsmith, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Penn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>111-36-4401</b>	
17. INFORMANT <b>Mr. George A. Goldsmith - Tompkinsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>825X</b> DUE TO (b) <b>Basilar Skull Fracture</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr. 29 min.</b> <b>1 hr. 29 min.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Highway Vehicular Accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:55 p.m. 6-6-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>RT. 3</b>		20f. (City or town) (County) (State) <b>Rock Point, Charles, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>V. B. Detton</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>V. B. DETTOR, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>6-6-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/9/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wayside, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>AREHART FUNERAL HOME, INC. - La Plata, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUN 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "ward" "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Belt</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>2239 Brudenell ave</u>	
3. NAME OF DECEASED (Type or print) <u>WOODSON WEST HARDY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30 1908</u> 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
13. FATHER'S NAME <u>John Hardy</u>		14. MOTHER'S MAIDEN NAME <u>Ada Hallion</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>576-10-5962</u>	
17. INFORMANT <u>Flossie Moreland</u>		Address <u>724 E North Bay Baltimore</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Coronary Thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u> <u>1 min.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>none</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Dropped dead.</u>
20c. TIME OF INJURY Month, Day, Year Hour <u>10:15</u> a. m. <u>6-8</u> p. m. <u>1959</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AT WORK</u>	
20f. (City or town) <u>WHITE PLAINS</u> (County) <u>CHARLES</u> (State) <u>MD.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>V. B. Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harold Grace</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archibute</u>		ADDRESS <u>Laplace</u>	
24a. REC'D BY REGISTRAR <u>Antonia S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Antonia S. Kraus</u>	
DATE <u>JUN 17 '59</u>			

10000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

507 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

LOW STATE  
HEALTH DEPT.

*[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6702 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06693

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>Charles</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benjamin</u>		c. LENGTH OF STAY IN 1b <u>83 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benjamin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Matilda</u> First <u>Jackson</u> Middle Last			4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1875</u>		9. AGE (In years last birthday) <u>83</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Nanj Smoy. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>					
13. FATHER'S NAME <u>James Butler</u>			14. MOTHER'S MARRIEN NAME <u>Harriet Gibson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Marshall Butler, Nanj Smoy. Del (Brother)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Heart Disease</u> (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Summed</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank A. Sagen M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/4/59</u>	
EXAMINER'S NAME (Type) <u>Frank A. Sagen M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10/2/59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Wilmington</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson &amp; Jenkins</u> ADDRESS <u>4804 Gates Dr.</u>		24a. REC'D BY REGISTRAR <u>JUN 8 1959</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 6703 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7,8,9,10 FilmG244 7-14-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pattuxent</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown, 04X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-40</u>
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Jones.</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy A. Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>215-38-5946</u>	
17. INFORMANT <u>Benjamin Jones. Huntingtown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 823X DUE TO (b) <u>Multiple simple and compound</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Fractures both legs &amp; femora</u> (c) <u>Fractures both legs &amp; femora</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u> <u>2 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - struck bridge - Route #381</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2:10</u> <u>a.m.</u> <u>6-27-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Pattuxent City, PG-CH.C. LINE</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>V.B. Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V.B. DETTOR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. [BURIAL, CREMATION, REMOVAL (Specify)] <u>6-30-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Edmunds</u>		22d. LOCATION (City, town, or county) (State) <u>Sunderland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pr. Sewell</u>		24a. REC'D BY REGISTRAR <u>Arthur &amp; Kline</u>	
ADDRESS <u>Pr. Friedrich, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THESE ARE THE  
FINDINGS OF THE  
MEDICAL EXAMINER

DEATH

*Handwritten signature: P. J. ...*

DEATH CERTIFICATE

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6704

## CERTIFICATE OF DEATH

06695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <b>WALDORF</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELMER</b> First <b>LAURENCE</b> Middle <b>KUHNERT</b> Last		4. DATE OF DEATH <b>JUNE 19 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>US-W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 FEB 1894</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-U.S. Govt</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Kuhnert</b>		14. MOTHER'S MAIDEN NAME <b>Agnes O'Connell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Nora Kuhnert, Waldorf, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage into GI tract.</b> DUE TO <b>Sarcoma of stomach &amp; metastasis</b> DUE TO <b>Diabetes mellitus.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>12 hr</b> <b>6 months</b> <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>18 June 1959</b> , to <b>19 June 1959</b> , that I last saw the deceased alive on <b>19 June 1959</b> , and that death occurred at <b>4:20 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur O. Woody</b>		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY, M.D.</b>		DATE SIGNED <b>20 June 59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-22-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

118885

CERTIFICATE OF DEATH

118885

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

118885

NO 118885  
First funeral home  
Address of funeral home  
District of Columbia  
A. J. A.

118885  
118885  
118885



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06696

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>None</u>		The Potomac River, Near Quantico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Prince William</u>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbridge-Rural</u>		83x-3 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>		d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edgar Franklin Miller</u>		First Middle Last		4. DATE OF DEATH <u>6-27-59</u> Month Day Year 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White-US</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-25</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Raymond Miller</u>		14. MOTHER'S MAIDEN NAME <u>Virgie Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>224-22-7024</u>		17. INFORMANT <u>Wife- Marjorie Miller Woodbridge Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatal Submersion</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Falling overboard from Yacht</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell overboard</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None Fell overboard</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>6-27-59</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James E. Andrews MD.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		6-30-59 DATE SIGNED	
EXAMINER'S NAME (Type) <u>17-Potomac Ave Indian Head Md</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodbridge</u>	
22d. LOCATION (City, town, or county) (State) <u>Manassas Va</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Mc Lepala Ref</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM3. Page 5 may be retained by our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 2/57

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6706 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Alton</b>		c. LENGTH OF STAY IN 1b <b>X Bel Alton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>X</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>LEO</b> Middle <b>MURPHY</b> Last		4. DATE OF DEATH <b>JUNE</b> Month <b>29</b> Day <b>1959</b> Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-4-13</b>
9. AGE (in years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>On Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Charles Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benjamin J. Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Dora Higgs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-40-9863</b>	
17. INFORMANT <b>Mrs. John Lyons-Sister, Bel Alton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>ca. 5 min.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Died in bed - no evidence of violence</b>	
20c. TIME OF INJURY Month, Day, Year <b>ca. 11:00 a.m. 6-29-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Bel Alton, Charles, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>V.B. Dettor</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>V. B. DETTOR</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>6-30-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Alton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc.</b> ADDRESS <b>Archart Funeral Home, Inc. - La Plata, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton L. Thomas</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06698

6707

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Doncaster (Rural)</b>		c. LENGTH OF STAY IN 1b <b>X</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Doncaster (Rural)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES</b> First <b>PENNY</b> Middle <b>Lost</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>22</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11</b> 1889		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milling</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saw Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Charles County, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Penny</b>				14. MOTHER'S MAIDEN NAME <b>Mitilda Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Mrs. Violet Simmons - Pisgah, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Hemorrhage</b> <b>331X</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>est. 15 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None Known</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Spontaneous onset at dinner table.</b>					
20c. TIME OF INJURY Month, Day, Year <b>6-22-59</b> Hour <b>6:50 p.m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>no injury</b>		20f. (City or town) (County) (State) <b>Doncaster, Charles, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>V.B. Detton</b>				DATE SIGNED <b>6-24-59</b>			
EXAMINER'S NAME (Type) <b>V.B. DETTOR M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/25/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Charles Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Johnson &amp; Jenkins</b>				24a. REC'D BY REGISTRAR <b>June 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6708 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pattuxent</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>04 X-2</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>SMITH</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-25</u>
9. AGE (In years last birthday) <u>16</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student-Farm laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Marie Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Marie Coby Prince Frederick</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock and Hemorrhage</u> <u>823X</u> DUE TO <u>Crush injuries of chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crush injuries of chest</u> DUE TO (c) <u>Crush injuries of chest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - struck bridge - Route #381</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:10 P.M. 6-27-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Pattuxent City, P.G. CH. CO LINE</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>V. B. DETTOR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>6-27-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-30-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Plum Point</u>		22d. LOCATION (City, town, or county) <u>Calvert, Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell Prince Frederick Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



RECEIVED  
JUL 10 1968  
STATE DEPT. OF HEALTH  
DIVISION OF VITAL RECORDS  
1000 PENNSYLVANIA AVE.  
ANNAPOLIS, MD. 21403

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-30

PLACE OF DEATH

RESIDENCE

IF NOT AT RESIDENCE, GIVE ADDRESS

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE

UNDERLYING

IF UNDERLYING, GIVE CAUSE OF DEATH

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IF UNDERLYING, GIVE CAUSE OF DEATH

Signature: *[Handwritten Signature]*  
Date: *[Handwritten Date]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove the other papers.

6709

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician Memorial Hosp.</u>		d. STREET ADDRESS <u>Rural, TOMPKINSVILLE</u>	
3. NAME OF DECEASED (Type or print) First <u>Estell</u> Middle <u>TEMPLEMAN</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 24 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Middleton</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Bell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Roger Templeman</u>		Address <u>Tompkinsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Central vascular accident</u> DUE TO (c) <u>Hypertensive heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>36 hrs</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>49</u> to <u>22 June</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>22 June</u> , 19 <u>59</u> , and that death occurred at <u>6:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur O. Woody</u>		ADDRESS (Street, city or town, state) <u>LA PLATA</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>		DATE SIGNED <u>22 June 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		22d. LOCATION (City, town, or county) (State) <u>Issa, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

CERTIFICATE OF DEATH

709

Name of Deceased *Charles*  
 Sex *Male*  
 Age *35*  
 Date of Birth *1911*  
 Place of Birth *Illinois*  
 Usual Residence *Illinois*

Date of Death *June 22*  
 Place of Death *Illinois*  
 Cause of Death *Heart Disease*

Name of Physician *Frank M. Hester*  
 Name of Hospital *St. Louis*  
 Name of Undertaker *James J. Taylor*  
 Name of Coroner *James J. Taylor*

Signature of Physician *[Signature]*  
 Signature of Coroner *[Signature]*  
 Signature of Undertaker *[Signature]*

Date of Report *June 24*  
 Name of Reporting Officer *ASTOR C. CROOK*  
 Name of Reporting Agency *LA 1242*  
 Name of Reporting Agency *WALSH*  
 Name of Reporting Agency *WALSH*  
 Name of Reporting Agency *WALSH*



6710

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>		d. STREET ADDRESS <b>/</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas</b>		4. DATE OF DEATH Month Day Year <b>June 8, 1959</b> 19	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1959</b>
9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Leroy Wills</b>		14. MOTHER'S MAIDEN NAME <b>Inez Theresa Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Inez Theresa Thomas, La Plata, Md.</b>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>atelectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JUNE 7, 1959</b> , to <b>JUNE 7, 1959</b> , that I last saw the deceased alive on <b>JUNE 7, 1959</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lorenzo Lopez</b> M.D.		ADDRESS (Street, city or town, state) <b>Physicians Memorial Hospital, La Plata, Md.</b>	
PHYSICIAN'S NAME (Type) <b>LORENZO LOPEZ</b>		DATE SIGNED <b>6-7-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/8/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Home Plot</b>	22d. LOCATION (City, town, or county) (State) <b>La Plata, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas L. Wills</b> ADDRESS <b>Father Beaton Rd</b>		24a. REC'D BY REGISTRAR <b>JUN 11 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kropa</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066172XVO

# CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DECEASED'S NAME

DATE OF BIRTH

PLACE OF BIRTH

DECEASED'S SEX

DECEASED'S AGE

DECEASED'S SEX

USA

DECEASED'S NAME

DECEASED'S NAME

DECEASED'S NAME

DECEASED'S NAME

TO

RECORDING OFFICE

RECORDING OFFICE

RECORDING OFFICE

RECORDING OFFICE

RECORDING OFFICE